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Meaningful Use – Then, Now and Beyond

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2015 Modification Rule

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Objectives

- Long Term Program Alignment
  - Meaningful Use in 2015 - 2018
- Meaningful Use Program for Eligible Professionals (EP) and Eligible Hospitals (EH) for 2015
  - Modified Stage 2
  - Removal of Core and Menu Objectives
  - Consolidation of Public Health Measures
- Medicaid EHR Program Attestation Updates
- Payment Adjustments
- IHIN

Long Term Program Alignment

MEANINGFUL USE IN 2015 - 2018

Stages of Meaningful Use

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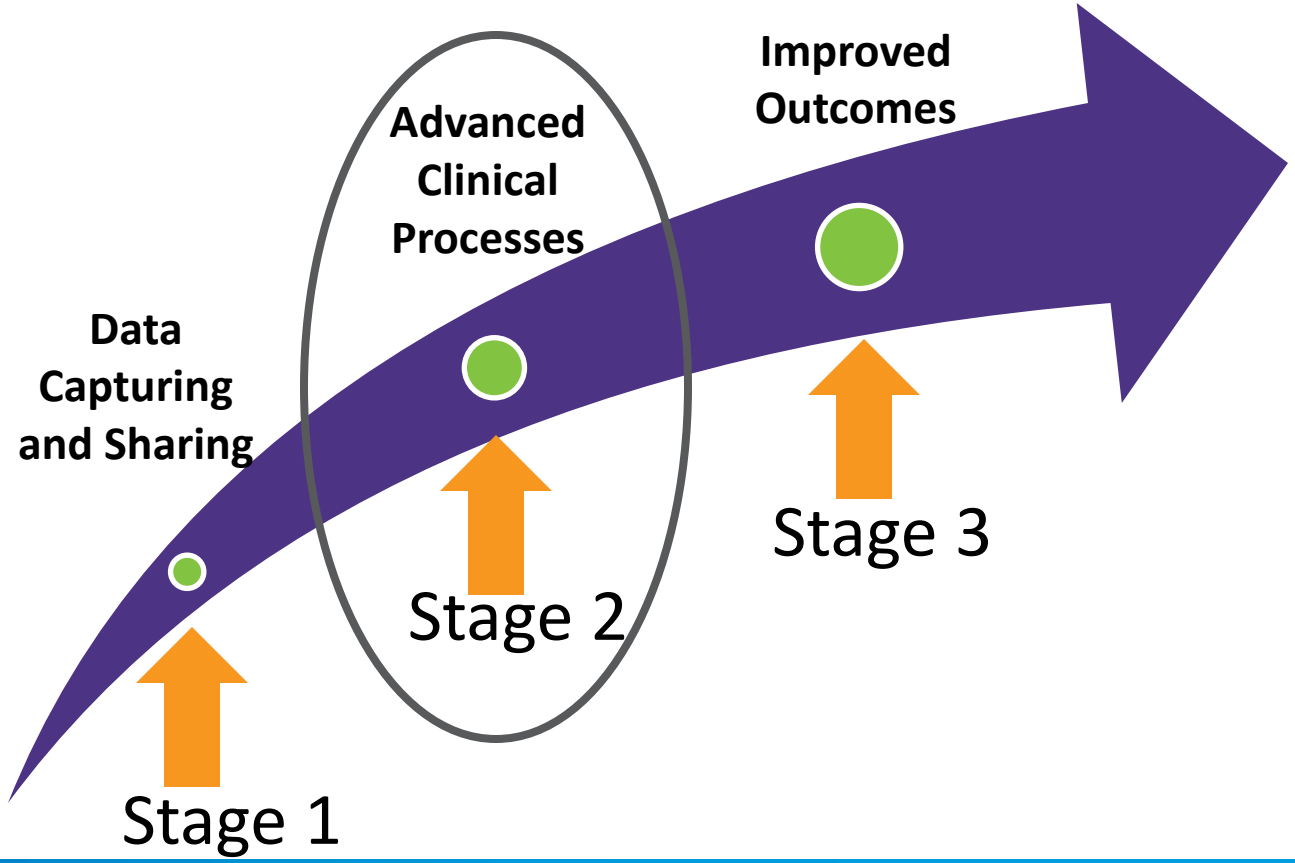
Stage 2: Advanced Clinical Processes



Long Term Program Alignment

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Participation Timeline

2015
- Attest to modified version of Stage 2 with accommodations for Stage 1 Providers

2016
- Attest to modified version of Stage 2, at stage 2 thresholds

2017
- Attest to either modified version of Stage 2 or full version of Stage 3, depending on availability of 2015 CEHRT

2018
- Attest to full version of Stage 3 with 2015 CEHRT

Long Term Program Alignment

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Meaningful Use in 2015

- Includes alternative exclusions and specifications for objectives for providers who were scheduled to demonstrate Stage 1 of Meaningful Use in 2015

  – EPs and EHs will be able to take an exclusion for any Stage 2 measure that does not have an equivalent objective in Stage 1

  – Exclusion to menu objectives which would now be otherwise required

Long Term Program Alignment

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Meaningful Use in 2016

- Starting in 2016 all providers will need to attest to the modified Stage 2
  - Must meet Stage 2 thresholds
  - 2015 exclusions will not apply in 2016
  - Reporting period will be for one full calendar year

Long Term Program Alignment

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Meaningful Use in 2017 and 2018

- 2017
  - Transitional year
  - Providers can attest to either modified Stage 2 objectives or Stage 3 objectives, depending on 2015 Certified EHR Technology availability
  - Reporting period will be for one full calendar year

- 2018
  - All providers MUST attest to Stage 3
  - All providers need to be on 2015 Certified EHR Technology
  - Reporting period will be for one full calendar year

Proposed Stage 3 MU Objective Groups

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- Protect Patient Health Information
- Electronic Prescribing
- Clinical Decision Support
- Computerized Provider Order Entry
- Patient Electronic Access to Health Information
- Coordination of Care Through Patient Engagement
- Health Information Exchange
- **8 Objective Groups**
- Public Health & Clinical Data Registry Reporting

Meaningful Use Program for EPs and EHs for 2015

MODIFIED STAGE 2

Modified Stage 2 Goals

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Proposed Provisions

- Align with Stage 3 proposed rule to achieve overall goals of programs
- Synchronize reporting period objectives and measures to reduce burden
- Continue to support advanced use of health IT to improve outcomes for patients

Modifications to MU in 2015 - 2017

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Proposed rule for Medicare and Medicaid EHR Incentive Programs:

- Streamlines program by removing redundant, duplicative and topped out measures
- Modifies patient action measures in Stage 2 objectives related to patient engagement
- Aligned reporting period with full calendar year
- Changes EHR reporting period in 2015 to 90-day period to accommodate modifications (not tied to a calendar quarter)

Updated Meaningful Use Timeline

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First Payment Year	Stage of Meaningful Use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	2	2	2	2 or 3	3	3	3	3
2012		1	1	2	2	2	2 or 3	3	3	3	3
2013			1	1	2	2	2 or 3	3	3	3	3
2014				1	2*	2	2 or 3	3	3	3	3
2015					2*	2	2 or 3	3	3	3	3
2016						2	2 or 3	3	3	3	3
2017							2 or 3	3	3	3	3

Meaningful Use in 2015

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- Starting in 2015 all participants will attest to a modified version of Stage 2 of Meaningful Use
  - Regardless of which year of Meaningful Use you are in, all participants will attest to a modified version of Stage 2 of Meaningful Use
  - Those providers who were scheduled to meet Stage 1 of Meaningful Use in 2015 will have alternate exclusions and specifications for certain objectives in 2015 only
  - All Meaningful Use Participants will be required to report on Stage 3 starting in 2018 for one full calendar year

Meaningful Use in 2015

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- All Eligible Professionals and Eligible Hospitals will move to any continuous 90 day reporting period for 2015
  - Eligible Hospitals will move to the calendar year for reporting period in 2015
  - Eligible Hospitals past their first year will have until February 2016 to attest to Meaningful Use
    - Eligible Hospitals in their first year will have until November 30, 2015 to attest to Meaningful Use
  - The CMS attestation system will not be ready until 2016 for the 2015 reporting period

Meaningful Use in 2015

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Modified Stage 2

- Any provider scheduled to attest to Stage 1 of Meaningful Use in 2015 will:
  - Attest to Stage 1 thresholds
  - Will take an exclusion for the Stage 2 measure if there is no equivalent Stage 1 measure
  - Menu objectives move to core objective

Proposed Stage 2 Structure

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Eligible Professionals

Current Stage 2

- 17 core objectives
- 3 of 6 menu objectives
- 9 CQMs from 3 domains

Proposed Stage 2

- 9 objectives
- 2 public health measures
- 9 CQMs from 3 domains

Proposed Stage 2 Structure

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Eligible Hospitals

Current Stage 2

- 16 core objectives
- 3 of 6 menu objectives
- 16 CQMs from 3 domains

Proposed Stage 2

- 8 objectives
- 3 public health measures
- 16 CQMs from 3 domains

Meaningful Use in 2015

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- There will be no changes to the CQM reporting or attesting
  - All EPs and EHs will still need to report CQMs for the Meaningful Use program
  - CQMs will need to span at least 3 of the 6 domains
  - CQMs can be electronically reported using established methods
  - CQMs will be reported for a 90 day period

Stage 2 Clinical Quality Measures

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Report on 9 CQMs

Quality Measures must cover at least 3 of 6 NQS domains:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population and Public Health
- Efficient Use of Health Care Resources
- Clinical Processes/Effectiveness

Vendor Requirements

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- 2015 – No changes to the 2014 CEHRT currently in use

- 2018 – Required to update CEHRT to 2015 standards

Reporting Year	Certified EHR Technology Edition
2015	2014 CEHRT
2016 -2017	2014 or 2015 CEHRT
2018	2015 CEHRT

Proposed Changes

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Qualifications for Hospital-Based EPs

- Include place of service 22 (outpatient) for those EPs considered hospital-based*
- EP is ineligible for incentive payment and payment adjustments if >90% covered professional services in sites of service identified as:
  - POS 21 (inpatient)
  - POS 22 (outpatient)*
  - POS 23 (emergency room)

Modifications to MU 2015-2017

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Proposed EP and EH Stage 2 Objective Changes

"Current" Patient Electronic Access

- Measure 1: More than 50% unique patients have timely online access with ability to VDT
- Measure 2: More than 5% unique patients VDT their information to a third party

"Proposed" Patient Electronic Access

- Measure 1: More than 50% unique patients have timely online access with ability to VDT
- Measure 2: **At least one patient** during the reporting period VDT their information to a third party

Modifications to MU 2015-2017

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Proposed EP Stage 2 Objective Changes

"Current" Secure Messaging

A secure message was sent using the electronic messaging function of the CEHRT by more than 5% of unique patients during the reporting period.

"Proposed" Secure Messaging

During the reporting period the capability to send and receive a secure electronic message with the provider is **fully enabled**.

MU Objectives 2015 -2017

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Objective	EP Measure	EH Measure
CPOE	>60% med, >30% lab, >30% radiology	Same
eRx	>50%; drug formulary query	>10%; drug form query
Clinical Decision Support	5 rules related to 4+ CQM; drug/drug and drug/allergy interaction ck	Same
Patient Elec Access (VDT)	>50% timely access; 1 patient VDT	Same
Protect Elec Health Info	Conduct SRA/correct deficiencies	Same
Patient Specific Education	>10% unique patients	Same
Medication Reconciliation	>50% transitions of care	Same
Summary of Care	Use CEHRT to create summary; >10% electronically transmit	Same
Secure Messaging	Fully enabled	n/a
Public Health	5 measure options	6 measure options

Meaningful Use Program for EPs and EHs for 2015

REMOVAL OF CORE AND MENU OBJECTIVES

MU Objectives Removed for EPs

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Removal for Modified Stage 2
Record Demographics Record Vital Signs Record Smoking Status
Clinical Summaries
Structured Lab Results
Patient List
Patient Reminders
Summary of Care Measures 1 and 3
Electronic Notes
Imaging Results
Family Health History

MU Objectives Removed for EHs

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Removal for Modified Stage 2
Record Demographics Record Vital Signs Record Smoking Status
Structured Lab Results
Patient List
Summary of Care Measures 1 and 3
eMAR
Advanced Directives
Electronic Notes
Imaging Results
Family Health History
Structure Labs to Ambulatory Providers

Meaningful Use Program for EPs and EHs for 2015

CONSOLIDATION OF PUBLIC HEALTH MEASURES

Meaningful Use in 2015

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Public Health Measure

- Consolidation of all public health reporting objectives into one objective with different measure options

EHs	EPs
• Immunization Registry Reporting • Syndromic Surveillance Reporting • Case Reporting • Public Health Registry Reporting* • Clinical Data Registry Reporting* • Electronic Reportable Laboratory Reporting	• Immunization Registry Reporting • Syndromic Surveillance Reporting • Case Reporting • Public Health Registry Reporting* • Clinical Data Registry Reporting*

* May choose to report to more than one registry to meet the number of measures required to meet the objective

Medicaid EHR Program

ATTESTATION UPDATES

Medicaid EHR Participants

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Additional attestation option

- Providers who have Medicaid patient volume fall below program thresholds will be able to avoid a Medicare payment adjustment by:
  - Will be able to attest using the CMS Medicare EHR portal
  - Medicaid participants will not earn an incentive for that program year
  - This does not affect their Medicaid program eligibility for subsequent years
  - Would not constitute a switch in programs

PAYMENT ADJUSTMENTS AND HARDSHIP EXCEPTIONS

EP Payment Adjustments

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- Payment adjustments began 1/1/15 for providers who did not attest by 10/1/14
- 2016 EP hardship applications are available on the CMS website
- Providers must attest EACH year to avoid Medicare payment adjustment
- Payment adjustments will stop after the calendar year it was applied if the provider meets MU
- Providers only eligible to participate in the Medicaid Program (i.e. PA, ARNP, CMW) are not subject to payment adjustment

EP Payment Adjustments

- Adjustment applied to the Medicare physician fee schedule amount for covered professional services furnished by EP during the year
- 1% payment adjustment per year
  - 1% - 2015
  - 2% - 2016
  - 3% - 2017
  - Government decision year 2018
    - o >75% of nation's EPs meet MU, payment adjustment caps at 3%
    - o <75% of nation's EPs meet MU, payment adjustments increase to 5%

Hardship Exception Application Categories

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EPs can apply for hardship exceptions by July 1, 2015 in the following categories:	
1. Lack of Infrastructure	EPs must demonstrate they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure.
2. Unforeseen and/or Uncontrollable Circumstances	Natural disaster, practice closure, bankruptcy or debt re-structuring, EHR Certification/Vendor Issues: •Loss of EHR Certification •Closure of EHR Vendor •2014 EHR Vendor Certification Issues and Delays
3. Lack of Control over the Availability of Certified EHR Technology	Lack of control of availability of CEHRT at one practice location or a combination of practice locations and where the location(s) constitute > 50% of patient encounters.
4. Lack of Face-to-Face Interaction	Lack of face-to-face patient interaction AND lack of need for follow up with patients OR extremely rare cases of face-to-face patient interaction and follow-up.

IHIN

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Benefits of Statewide HIE/IHIN

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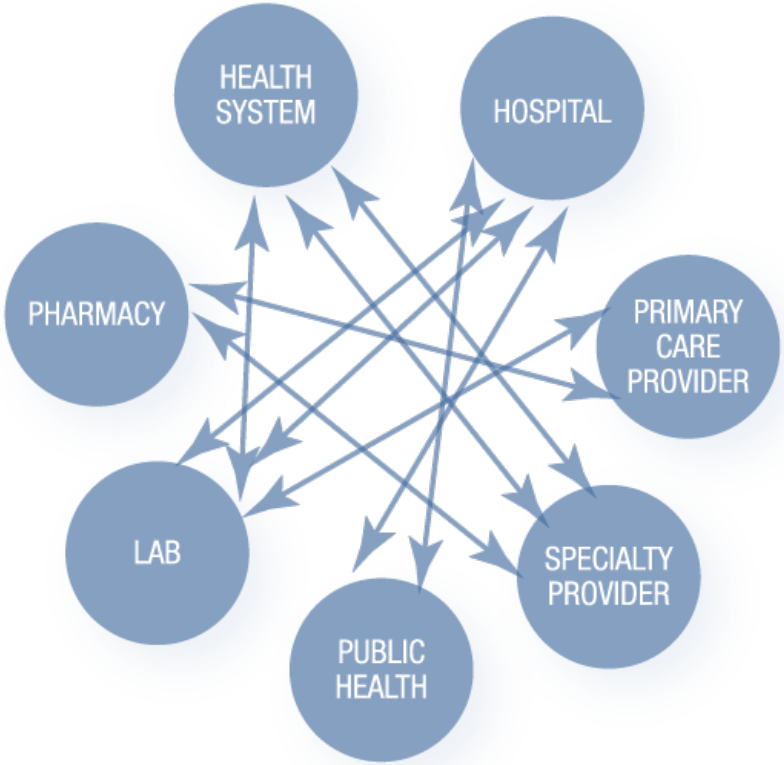
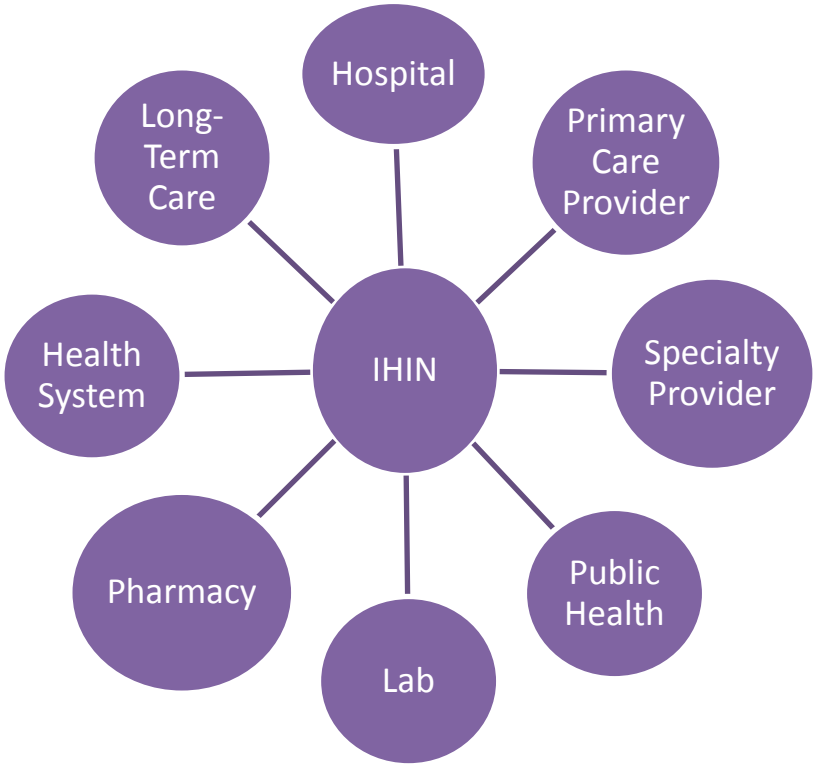
Without the IHIN
Each healthcare provider must build point-to-point connections.



With the IHIN
Each healthcare provider is connected.



Core IHIN Services

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- Direct Messaging
- Patient Query/Look-Up
- State Public Health Reporting

Direct Messaging

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- Send/receive patient information in a secure method with providers outside your organization
  - Direct works like conventional email but encrypts the message, enabling electronic transfer of protected health information (PHI) to an authenticated user
- *Push* messaging
- Used for treatment, payment and healthcare operations
- Approved for use among all provider organization types

How to Connect…Direct Messaging

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- **System to System Connection**
  - EHR interface
  - Technical protocols, testing required
- **Clinical Portal**
  - Interface is via the Internet
  - Accessible, even without an EHR

Note: Direct Messaging with IHIN requires a DirectTrust accredited HISP.

HISP = Health Information Service Provider

Direct Messaging

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Direct Messaging Exchange Use Cases

Referral	When referring a patient, a primary care provider can use Direct to send the necessary patient information to a specialist
Transition of Care	When admitting a patient to a long term care facility, the provider can use Direct to send a treatment summary to the facility
Hospital Discharge	When discharging a patient, the hospital can use Direct to send the discharge instructions to the primary care provider
Communication	Direct is an efficient communication tool where documents can be attached to a secure email, resulting in a reduction of the number of faxes & phone calls sent

THANK YOU

CMS Resources

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- http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Modifications_MU_Rule.pdf
- http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html
- http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage3_Rule.pdf

Questions?

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